Necessary Information

Name: _____ **Date of Birth**: _____

Address: _____

City/State/Zip: _____

Home Phone/VP: _____ **Work:** _____

May I contact you at home? *(Check one)* ☐ **Yes** ☐ **No** **At work**? ☐ **Yes** ☐ **No**

E-mail or Pager: _____

Age: _____ **Gender**: _____ **Social Security Number***: _____

Emergency Contact: _____

Brief Health History

Physician's Name: _____

Physician's phone: _____ Date of Most Recent Exam:_____

Are you being treated for a medical illness? ☐ **Yes** ☐ **No** If yes, please list illness below:

_____

Are you currently taking any medications? ☐ **Yes** ☐ **No** If yes, please list them below**:**

_____

Do you have any allergies? ☐ **Yes** ☐ **No** If yes, please list below:

_____

Have you been in therapy before? ☐ **Yes** ☐ **No**

If yes, was the experience helpful? ☐ **Yes** ☐ **No**

How were you referred to my service? _____

If you are under the age of 18, please fill out the reverse side of this form.
**SSN is necessary for billing purposes only*

If you are a minor under 14 years of age or if a parent is responsible for your bill:

Parent's Name: _____

Parent's Address: _____

City/State/Zip: _____

Telephone #'s _____

I have reviewed this document for my child and I attest, if applicable, that I am the custodial parent. I have reviewed and signed a *Consent to Treatment* form for my child or have provided consent by the signature of the other parent.

_____
Signature of Parent

_____ _____/_____/_____
Printed Name of Parent Date

Parent's Name: _____

Parent's Address: _____

City/State/Zip: _____

Telephone #'s _____

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_____
Signature of Parent

_____ _____/_____/_____
Printed Name of Parent Date

Using Insurance

What You Need to Know

Please know that my office submits insurance claims electronically through a professional practice management billing service known as Secure Connect. This will include the information you submit below as well as additional information required for billing purposes such as, but not limited to, date of service, applicable diagnosis code(s), and billing codes for the service rendered. I must have your express permission to bill your insurance company for any service provided and to participate in any quality or utilization review that they might require. You should be aware that your insurance company may review your file at any time.

If you do not wish my office to bill your insurance for you, please do not complete this form.

Please be aware that unless otherwise explicitly stated, you remain responsible for charges incurred.

The undersigned hereby authorizes the release of information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes Mr. O'Dell to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for me and/or my dependents. This signature will bind me as though I have personally signed the particular claim.

Name of Insured: _____ Insured date of birth: _____/_____/_____

Address of Insured: _____City, State & Zip_____

Relationship of client to insured: _____ Employer of insured:_____

Insurance Company: _____ Insurance Phone Number: _____

Insurance Company Address: _____City, State, Zip_____

Insurance ID Number: _____ Group Number: _____

_____ _____/_____/_____

<Signature> **<Date>**

The Lighter Heart PC

Informed Consent for Treatment

Why Informed Consent?

Psychotherapy is not an exact science. It is important for you to know something about the kind of treatment you will experience, expectations about fees, confidentiality and the process for dealing with any concerns about your treatment.

What Is Psychotherapy?

Psychotherapy is often thought of as a process in which uncomfortable areas of your life are identified and explored. During this process, various options for change will be discussed, exercises or activities will be suggested, and you may come to a greater understanding of how to live as you wish. In order to be successful, psychotherapy requires an investment of your time and energy and the process has both benefits and risks. Occasionally, individuals go through periods during treatment that result in emotional discomfort, changes in relationships, or temporary worsening of particular symptoms. These should subside as the work progresses and as you become clearer on how to promote your own emotional well-being.

My particular style of psychotherapy is based on the understanding that our beliefs shape our experience. Talking about your experiences and feelings is one of many ways to explore patterns which arise and which may be interfering with your current life satisfaction. Psychotherapy is often an experience of re-learning, one in which old beliefs, values and attitudes can be examined to see if they are truly helping you live as you wish.

You may be asked to do exercises or activities to help you be in touch with how your feelings and beliefs are working. Please remember that you have the right to refuse any particular therapeutic technique or to request a change in your treatment; however, we must be able to talk about your current experience, thoughts and feelings.

Therapy has no specific beginning or ending and it is not useful to estimate how long it will last as it will depend on the work you do outside the therapeutic hour. As one particular issue resolves, another may arise. These other issues may need attention, or they may not. We will continually review your desire for change, devise techniques of healing specific to you, and discuss your level of comfort with how therapy is going.

Confidentiality

Any information discussed in the course of treatment and/or evaluation will be held in strict confidence and will not be communicated to any person or agency without your written permission. Additionally, it is my policy to respect your right to privacy; therefore, I will *not* acknowledge you outside the therapeutic setting without express consent to do so. **There are, however, limitations and exclusions to confidentiality.** These include (1) statements that you might make of intention to commit suicide, (2) statements that you might make of intention to commit homicide with respect to named or readily identifiable persons, (3) statements indicating that you have committed or intend to commit acts of child abuse, (4) statements indicating that you have committed or intend to commit acts of abuse against the elderly, and (5) information that would facilitate your treatment in a life threatening, medical emergency.

Should our therapy be terminated prematurely due to the unlikely event of my death, your file will be open to Kay Gage, MS, RN, or another associated clinician who would work with you to arrange continuation of treatment.

SIGNATURE REQUIRED ON REVERSE OF FORM

Concerns About Therapy

If you have questions or concerns about the conduct of your therapy, please talk with me as soon as the question arises or the concern is experienced. If discussion does not resolve the concern or if you feel that civil or criminal damages have occurred, please contact the Oregon State Board of Clinical Social Workers at 3218 Pringle Road SE Suite 40, Salem, Oregon 97302-6310. My Oregon license number is 2226. My board certification is through the American Board of Examiners in Clinical Social Work, 27 Congress St., Suite 211, Salem, Massachusetts, 01970.

My Diplomate number is 27765.

Availability

I am generally available by phone Monday through Friday from 10:00 am until 6:00 p.m. Voice mail is paged to my attention and calls are generally returned within 24 hours. If you have an urgent need after my general office hours, please follow the voice mail instructions for paging. **However, if you feel you cannot wait for a return call,** please call your local crisis center. In Salem, the telephone number is (503) 585-4949; in the Portland metropolitan area, the telephone number is (503) 988-4888. Each center is staffed 24 hours a day, 7 days a week.

Fees

My usual and customary fee is $150.00 for an evaluative session, $110.00 for individual psychotherapy, and $125.00 for family or "conjoint" therapy. If you are using insurance to assist in the cost of treatment[*], it is your responsibility to check with your insurance company or managed health care organization to determine your coverage for mental health services. I will bill applicable insurance, employee assistance and managed health care organizations as a courtesy; however, you are ultimately responsible for the cost of services. You will be charged for missed appointments not cancelled 24 hours in advance and, for these appointments, insurance will not be billed

Should you have questions or concerns about fees please discuss them with me as soon as they occur.

Payment is expected at the time services are rendered unless prior arrangements are made. There is a $7.50 monthly charge for any account outstanding. Accounts more than 90 days in arrears are subject to collections with Western Credit and Collection Services, Inc or Portland, Oregon.

Request and Consent for Treatment

I hereby request and agree to engage in a course of psychotherapy with Steven "Bo" O'Dell, LCSW. I understand that I will jointly decide about the goals and the nature of my treatment. I understand that I can revoke this consent at any time. I have read on-line, requested a copy, or have otherwise reviewed and understood the office policy on privacy and confidentiality.

By my signature I indicate that I have read and understood the above material.

Signature:_____

Printed Name:_____Date:_____/_____/_____

→ **NOTE**: Please complete the questions on pages 8 and 9, and use the SUBMIT or PRINT buttons shown on the final page 10. The form should be emailed to **bo@thelighterheart.com**.

[*] please see additional printed information about *Using Insurance; What You Need to Know*

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YOUR COPY TO KEEP

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Intake and Assessment Client Form

Getting to know more about the problem or problems that have brought you (or your child) here is an important step in starting therapy. Please take a few minutes to complete the questions below and the pre-therapy testing on the pages that follow.

Please briefly describe how you perceive yourself:

How do you think other people perceive you?

If you are having any of the following symptoms, please check:

☐ Depression	☐ Extreme Sadness	☐ Trouble Concentrating	☐ Lack of Energy
☐ Memory Problems	☐ Change in Eating	☐ Perfectionism	☐ Feeling of Extreme Happiness
☐ Low Self-esteem	☐ Lack of Enjoyment	☐ Feeling Fearful	☐ Trouble Performing Your Job
☐ Physical Pain	☐ Feeling Tearful	☐ Problems with Anger	☐ Obsessions or Compulsions
☐ Feeling Hopeless	☐ Change in Sleep	☐ Weight Change	☐ Thoughts About Suicide
☐ Feeling Stressed	☐ Feeling Irritable	☐ Feeling Nervous	☐ Change in Sexual Interest/Desire
☐ Sudden Panic	☐ Fatigue	☐ Feeling Violent	☐ Thoughts of Homicide

Was there any event or activity that happened just before you noticed these things?

- Do you use tobacco in any form? ☐ Yes ☐ No About how much? _____
- Do you use alcohol (include social use)? ☐ Yes ☐ No About how much? _____
- Do you use caffeine (including cola drinks ☐ Yes ☐ No About how much? _____
- How much sleep do you get on average? _____ Is that enough? ☐ No ☐ Yes
- Do you dream? ☐ Yes ☐ No

_____

<Your Name>

THERAPY GOALS

What are your reasons for seeking help at this time? Please be specific.

How is this affecting your life on a day-to-day basis?

Are there any specific situations where this shows up for you?

What is you desired outcome for therapy? Include a list of therapy goals.

Please list 3 experiences that made you feel alive.

Print Form

*If you've saved the form to your computer and have Adobe Acrobat, you can complete the electronic form then print and bring to your first appointment.

→ **NOTE**: If you have questions, you can reach my office **bo@thelighterheart.com**, 503-249-7844